

Centers for Medicare and Medicaid Services

WASHINGTON MEDICAID ASSESSMENT REPORT

COMMUNITY ALTERNATIVES PROGRAM WAIVER

Control Number 0050.90.R2

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EXECUTIVE SUMMARY

The review of the Washington Community Alternatives Program (CAP) waiver was conducted as part of the Centers for Medicare and Medicaid Services' (CMS) ongoing monitoring and evaluation of the subject waiver. It was designed to determine if the State of Washington was in compliance with federal guidelines and with the approved waiver document. To ensure adequate coverage of the areas of review, the review covered the period July 1, 1997 through January 31, 2002.

Our review showed the State was in compliance with some of the federal waiver requirements. It also showed the State implemented several innovative quality assurance initiatives and was aggressively pursuing the development of a comprehensive quality assurance system. However, we found several significant problems with the State's implementation of the CAP waiver. Deficiencies were found in the areas of: access to care; Medicaid eligibility; CAP waiver eligibility; assessment of need; client plans of care; financial accountability; and fair hearings. These problems created situations where CAP participants were at unreasonably high risk of having their health and wellbeing compromised. The deficiencies also resulted in ineligible people securing Medicaid State Plan and waiver services. The Medicaid overpayment associated with providing services to ineligible individuals was significant. The ineligible individuals fell into three categories: (1) people granted exceptions to policy; (2) individuals in excess of the approved CAP ceiling; and, (3) people not meeting 42 CFR 435.217 eligibility requirements. We also found the State had adopted laws and policies inappropriately limiting access to Medicaid State Plan services provided by intermediate care facilities for the mentally retarded. This situation placed the State in non-compliance with federal law and Washington's Medicaid State Plan. Non-compliance of this nature could jeopardize future federal funding of the State's Medicaid program. We have recommended the State take the steps necessary to correct the problems identified during our review and refund the federal funds attributed to extending Medicaid State Plan and CAP services to ineligible people.

The State concurred with and submitted a corrective action plan to implement some of our recommendations. It disagreed with our recommendations concerning client access to health care, case management staffing, Exceptions to Policy, claims processing and payment, the application of waiver related eligibility provisions, excess enrollees and barriers to accessing ICF/MR services. The State provided a corrective action plan to implement partially our recommendations on ensuring CAP clients are fully informed about alternative health care and unproven treatments or process, eliminating the legal, regulatory and procedural provisions that encourage denying needed services based on funding limitations, and correcting the problems associated with plans of care. The State also disagreed with many of the facts and conclusions contained in the report. The State's position on these matters along with our response can be found immediately following the Recommendations section of this report. The complete text of the State's

response to the findings and recommendations is contained in the Attachment to this report.

INTRODUCTION

The Health Care Financing Administration (HCFA) approved Washington's Community Alternatives Program (CAP) waiver under Section 1915(c) of the Social Security Act for a five-year period beginning July 1, 1997. The waiver is designed to provide home and community-based services to approximately 13,000 individuals who would otherwise require the level of care provided in an intermediate care facility for the mentally retarded (ICF/MR facility). The services available under the waiver include: habilitation, respite care, environmental accessibility adaptations, skilled nursing, transportation, specialized medical equipment and supplies, private duty nursing, attendant care, adult foster care, behavior therapy, alternative living, staff/family consultation and training, adult day health, physician, occupational therapy, speech, hearing and language, physical therapy, and other medical services. The Division of Developmental Disabilities (DDD) is the unit within the Department of Social and Health Services (DSHS) responsible for the administration of the waiver.

SCOPE

We conducted the review at the State offices in Olympia and various local offices during the months of July 2001 through January 2002. We also made on-site visits to several residential care providers during this time period. The objectives of the review were to determine: (1) if the waiver activities complied with applicable federal regulations and the requirements of the approved waiver document; and, (2) whether the State had developed an effective system for ensuring the health and safety of individuals placed in residential settings. To accomplish these objectives, we focused review efforts on evaluating the design and implementation of the State's quality assurance system along with the systems in place for ensuring financial accountability, services are provided by qualified providers and plans of care are properly developed, implemented and monitored. We also focused our review efforts on evaluating the State's general administration of the waiver and the process and instruments used for evaluating level of care. The data necessary to complete our evaluations was obtained from the records maintained by the State and providers as well as through interviews with State staff, advocacy groups, provider personnel, clients and client representatives/guardians.

FINDINGS AND RECOMMENDATIONS

Quality Assurance System

DDD traditionally assigned responsibility for most quality control activities to its six regional offices. Each regional office was allowed to focus its quality assurance activities in areas it deemed appropriate and develop its own quality assurance initiatives. This approach led to the development of many noteworthy projects but did not encourage the development of comprehensive statewide initiatives. DDD recognized this shortcoming and began developing a comprehensive quality assurance program for statewide application. At the time of our review, DDD was in the process of cataloging its ongoing quality control activities and finalizing the framework for its quality assurance program. A draft of the framework indicated it would identify the components of quality assurance; assign quality assurance roles and responsibilities; and list the expected outcomes of the program. Our analysis of the planned quality assurance activities and discussions with DDD staff indicated the final version of the DDD quality assurance program will include all of the elements of an effective quality assurance system and should contribute significantly to ensuring the health and welfare of CAP clients.

Over the years, the State had implemented policies and procedures covering a number of quality assurance areas. These instructions led to the development of systems addressing a wide variety of issues including: obtaining client feedback; resolving complaints; identifying, addressing and preventing client abuse, neglect and exploitation; accessing services; disseminating information to clients and providers; and monitoring provider performance. We found most of the quality assurance systems were operating satisfactorily and contributing towards maintaining the wellbeing of CAP participants. We also identified several quality assurance initiatives undertaken by DDD regional offices that were especially noteworthy. In addition, the State's processes covering licensure and certification of residential service providers appeared very effective. Our observations concerning these two areas, along with the problems we found with access to needed services, are described in the following sections titled Residential Service Initiatives, Regional Initiatives, and Access to Needed Services.

Residential Service Initiatives - DSHS implemented a very strong licensure, inspection and enforcement program to protect the health and safety of CAP participants residing in group homes and adult family homes. Prior to granting a license, DSHS required that each adult family home and group home to complete a detailed application that included a fire marshal inspection. Once a license was granted, the facility was subjected to annual evaluations designed to ensure adult family homes and group homes continued to maintain high standards. If an annual evaluation identified a deficiency, the provider was notified and a corrective action plan was implemented. Procedures also allowed licensure staff to require that providers immediately correct deficiencies posing an immediate and serious threat to the wellbeing of residents and issue stop placement

orders if the situation warranted such action. Providers who failed to comply with their corrective action plans were subject to termination of their licenses. Communication paths existed to ensure DDD staffs were immediately advised of any provider who had been terminated so appropriate action could be taken to relocate CAP clients residing in the terminated facility and prevent placing other CAP participants there.

DDD also had a certification program for group home and supported living/tenant support providers. The certification program was based on the same concepts as the licensure, inspection and enforcement program. The two programs also shared many of the same processes. The major differences between the two initiatives were: certification reviews were conducted by independent contractors; the period between reviews could be two years for certification; and all health and safety issues identified during certification reviews were referred to DDD for resolution. DDD recently implemented policies transferring the responsibility for monitoring certification based corrective action plans from the regional offices to its central office. This change was made to provide greater assurance that corrective action plans were tracked and satisfactorily implemented.

We accompanied DSHS licensure inspectors on the annual reevaluations of two adult family homes. We also accompanied certification reviewers on their visits to a group home and a supported living/tenant support provider. Our reviews at these providers focused on analyzing the compliance history of the providers, observing the licensing and certification reviewers and determining if needed enforcement actions were taken. We found the licensure inspectors and certification reviewers did a commendable job in all phases of the inspection, review and sanction processes. Each of the four providers visited received their licensing inspection or certification review within the required time period. The reviews and inspections observed followed the State's protocols, appeared to be consistent from one inspector/evaluator to another, and utilized acceptable interpersonal skills for conducting a review.

During the certification review of the supported living/tenant support provider, the certification team noted several CAP clients had not received annual physicals from their medical doctors. We pursued the certification team's observations and found 70 percent of the clients served by this provider were receiving ongoing naturopathic care. We also learned that a client's naturopathic provider, instead of his or her medical physician, was usually contacted when the individual experienced a health crisis. These facts strongly indicate naturopathic care was used to replace rather than complement allopathic medical care. Although CMS does not object to people accessing naturopathic care, the Medicaid program does not recognize it as a substitute for allopathic medical care. The documentation maintained by the provider also suggested there was very little, if any, communication between the clients' naturopathic providers and their physicians. The lack of communication among a person's health care providers could prove problematic for individuals receiving treatment from more than one provider. For example, herbs and pharmaceuticals can themselves adversely affect an individual's health. In addition, herbal preparations can adversely affect the efficacy of drugs with narrow therapeutic

ranges and those used to treat chronic medical conditions. To avoid these and other problems associated with receiving care from more than one provider it is essential to ensure the two are aware of the care being provided by each other. Communication among health care providers also facilitates the development of comprehensive treatment plans that take into consideration the treatment philosophies of all those involved in the process.

Our findings concerning access to medical care and coordination among health care providers confirmed the findings of the State contracted certification team. Certification evaluators had identified both issues during their current and previous review of the provider. The certification evaluators reported the problems to the provider and DDD at the conclusion of the previous review but the steps necessary to correct the deficiencies were not taken. Evidence suggests the problems remained uncorrected because of a breakdown in DDD's process for following-up on certification review findings and recommendations. Apparently, DDD staff did not monitor the provider's implementation of its corrective action plan and management did not adequately oversee staff monitoring efforts. DDD's new policies will require central office monitoring of all corrective action plans. These new policies indicate the State will be able to ensure similar problems with implementation of corrective action plans do not occur in the future.

During our visit to the supported living/tenant support provider, we also identified areas where informed choice appeared to be an issue. One of the areas involved the use of facilitative communication. Facilitative communication is a controversial technique in which a facilitator supports the hand or arm of a person who is communicatively impaired while the person communicates using a keyboard or typing device. The technique is claimed to enable people with autism or moderate to profound mental retardation to communicate. A substantial number of studies have found the claimed benefits of facilitative communication could not be scientifically validated. The results of these studies led the American Association on Mental Retardation, American Psychiatric Association, American Academy of Child & Adolescent Psychiatry and the American Academy of Pediatrics to adopt the position that information obtained through facilitative communication should not be used as a basis for making important decisions.

We found that the provider strongly supported the use of facilitative communication. Staff members received in-depth training on the theory and application of facilitative communication and were encouraged to use the technique when dealing with clients. Facilitative communication was also used by the provider as a marketing tool to attract new clients. The commitment to the use of facilitative communication was evident in a situation where a client, through facilitative communications, alleged seven separate incidents of physical abuse. The client's housemate was identified as the perpetrator of the abuse. The client also indicated he was scared and did not want to continue living with the abusive housemate. There was no evidence suggesting the provider used other communication techniques to validate the client's allegations or desire to change his living situation. In addition, there was no documentation showing the provider made an

attempt to act upon the client's facilitative communications. We found no information indicating the provider initiated steps to address the client's fears or relocate either person.

The provider's response in this case raised a number of concerns regarding its approach to client care and informed choice. The failure by the provider to employ alternative communication techniques and properly address situations of reported abuse was reported to DDD by the certification team and a corrective action plan was implemented. The issue of informed choice was outside the scope of the certification review; however, we believe it is important and warrants attention. It appeared some clients were drawn to the provider by its reported devotion to facilitative communication. We are concerned whether the client's guardians/representatives were advised that information obtained through facilitative communication would not be relied upon to address major issues affecting clients. We are also concerned that the guardians/representatives were not informed that alternative communication techniques would not be used in situations where facilitative communications were deemed unreliable. The guardians/representatives must know the full risks and benefits of facilitative communication along with the provider's approach to utilizing other techniques so they can make informed choices among providers.

The other area where informed choice appeared to be an issue involved the use of naturopathic care. As stated previously, a very high percentage of CAP clients who received services from one of the providers visited used naturopathic care. We realize clients and their representatives freely chose to receive naturopathic care and agreed to pay for its cost. In addition, we support the concept of allowing clients to choose the types of care they receive including naturopathic and other types of alternative treatment. However, we are concerned about whether the individuals who made these decisions made informed choices.

We did not fully study these two situations but believe they warrant reporting and additional attention by DDD.

Regional Initiatives – We found numerous examples where DDD regional offices had initiated innovative and effective quality assurance projects. One region was involved in a pilot project designed to assess the quality of care provided by individual providers. The project included surveys of clients, parents and providers that were conducted in-person, via telephone and through the mail. These surveys identified several areas where the quality of care provided by individual providers could be improved. The survey tools used also proved valuable in educating clients and their families on what they should expect from their providers. Based on the success of the project, DDD was considering replicating the initiative throughout the State. Another region initiated a quality assurance project centered on consumer satisfaction. This initiative required supervisors to randomly select four cases per month for review. The supervisors were required to conduct a client satisfaction survey for each case selected. In addition, one

of the four clients chosen had to be referred to a service authorization team for analysis of the payment aspects of the case. The supervisors could use a mail survey for one of the clients but needed to contact the other three by telephone. After the supervisor completed the consumer satisfaction portion of the review and received the results of the financial evaluation, he or she was required to complete a report summarizing the results of the review. The report also contained a section for explaining the corrective action needed to resolve any problems identified. Upon completion, the report was forwarded to the Field Services Administrator for review. The supervisor was also responsible for following-up with the appropriate case manager to resolve any problems identified during the review. This same region initiated another quality assurance program centered on consumer satisfaction. This program required case managers to provide a client with a mail-in survey form after each client contact. Supervisors also participated in this program by mailing satisfaction survey questionnaires to clients.

Incident Reporting – DSHS required all instances of client abuse, neglect and exploitation to be reported to its adult and children protection units. The two units were responsible for investigating these types of allegations and referring their findings to the appropriate authorities. DDD also developed a comprehensive system for reporting incidents such as theft, injury, medication error and death. The DDD system was a web-based application and operational in all DDD regional offices. Case managers were responsible for gathering incident information and entering the data into the DDD system. Case managers were also required to follow-up on incidents and ensure they were satisfactorily resolved. To ensure case managers were aware of their responsibilities, DDD developed a mandatory training program. The training case managers received included instructions on what information should be captured, how to enter the information into the system and what follow-up action was required. A program for monitoring case manager performance was another important feature of DDD incident reporting effort. This monitoring effort was focused on ensuring case managers properly track and satisfactorily resolve incidents relating to client health and wellbeing.

The State's incident reporting system provided a very good tool for capturing data and monitoring staff work. We did find one provider had compromised the system by not reporting incidents in a timely manner. This problem was noted by the DDD certification team and a corrective action plan implemented. We also learned DDD was involved in reviewing incident data with the intention of making the incident reporting system a more effective component of DDD's quality assurance program. This effort, combined with DSHS' continuing commitment to reduce abuse, neglect and exploitation of vulnerable people, should ensure incidents are reported within established time frames and appropriate corrective action taken. DDD's planned enhancements should also prove beneficial in identifying opportunities for DDD to develop strategies for preventing incidents from occurring.

Access to Needed Services - Our analysis of case files identified several instances where individuals were denied waiver services. The clients were denied these services

even though their CAP assessments and plans of care clearly showed the services were necessary for the individuals to live successfully in the community. We also received numerous complaints alleging clients were denied needed services. Our follow-up on the complaints confirmed many of the allegations. The services that were denied included residential habilitation, prevocational services, supported employment services, attendant care, alternative living services, respite care, occupational therapy, physical therapy and speech therapy. We discussed these findings with several DDD staff and learned it was common practice to deny CAP participants needed services. We were also told the denials were required because funding was not available to pay for the services.

The practice of denying CAP clients needed services was originally brought to our attention in January 2001. At that time, we were concerned the State legislature may have decided not to appropriate enough monies to sufficiently fund the CAP waiver. We were also concerned provisions of the Revised Code of Washington (RCW) prevented DSHS from redirecting monies from other appropriations to meet the funding needs of the CAP waiver. RCW 71A.10.010 contained a statement that the legislature intended to provide persons with developmental disabilities services only to the extent funds were provided by the legislature. In addition, the provisions of RCW 71A.10.010 had been submitted into evidence at fair hearings as justification for DDD's decisions to deny needed CAP services. We wrote DSHS and explained it could not limit access to covered waiver services simply because of the lack of available funding. We also informed DSHS it could not place a ceiling on the number of CAP clients who may receive a particular waiver service. These prohibitions are required to ensure: (1) the needs assessments of waiver clients are not undermined; (2) feasible services are not converted into services that arbitrarily benefit some waiver participants but not others who may have equal or greater need; and, (3) the health and welfare of waiver participants is not jeopardized.

DSHS responded to our inquiry and acknowledged that State statutes dealing with services for developmentally disabled individuals contained language limiting the provision of services to the extent funding was appropriated by the legislature. However, DSHS did not believe a change in State law was warranted. DSHS stated it believed it had enough flexibility under current law to direct funds to those areas where services were required. DSHS also stated that the statutes should be not be used as a basis for denying Medicaid funded services that are required by law.

Based on DSHS' response to our January 2001 inquiry and the findings from our on-site visits, we could not determine why DSHS did not provide funding for waiver services. Regardless of the reason, inadequately funding needed CAP services is not acceptable. This practice directly conflicts with the approved CAP waiver and places people in situations where they face unreasonable risks to their health and welfare.

The State has a number of options available, other than denying people needed services, if it desires to limit funds used to support CAP clients in the community. One

option would be to limit the number of people allowed to enroll in the waiver. Another option would be to reduce the number of services available through the waiver. Reducing the number of covered services would enable the State to save money in two ways. First, expenditures for the non-covered community services would be eliminated. Second, those people who could no longer have their needs met through the CAP waiver because of the reduction in covered services would be precluded from participating in the CAP program. Whichever option the State may elect to pursue, it must ensure it commits sufficient funds to ensure CAP participants receive all of the waiver services they are assessed to need.

We also had concerns that CAP clients were experiencing difficulty accessing mental health care and alcohol/substance abuse treatment. Our concerns were based on the findings of a study commissioned by the Washington State Office of Attorney General as well as complaints received by CMS. We explored this issue and found the Division of Mental Health (DMH) and DDD were participating in a joint effort to remove the barriers limiting access to mental health services. The joint effort involved: providing training to DMH and DDD personnel on the mental health needs of DDD clients; developing long term mental health treatment centers accessible to the developmentally disabled; enhancing available crisis intervention and prevention services; and including access to mental health services in the DDD quality assurance program. We also found the problem with accessing alcohol and substance abuse treatment was more an issue of accessing appropriate and effective treatment than merely enrolling in a program. Apparently, there were only a few treatment programs designed to accommodate the special needs of the developmentally disabled. DDD staff stated they began addressing this problem by establishing ongoing working relationships with those individuals and organizations involved in treating alcohol and substance abuse. DDD believed these relationships would enable it to ensure DDD clients had access to effective and appropriate treatment programs. Based on our discussions with DSHS personnel and examination of available documentation, it appeared significant progress had been made in improving access to mental health care and alcohol/substance abuse treatment. Continued efforts by DMH and DDD should further enhance access to both services.

Plans of Care

The State had established procedures to ensure individuals who were potentially eligible to participate in the waiver were informed of their options and instructed on how to apply for waiver services. The choice process began after the individual was determined to qualify for participation in the CAP waiver. If the person could have their needs met through the waiver, they were given the opportunity to request enrollment in the waiver. The client's choice was then recorded on the Voluntary Participation form. The Voluntary Participation form was then signed by the client and placed in the client's case file.

The next step in the process was the development of the individual's plan of care. The plan of care was the fundamental tool by which the State ensured the health and welfare

of people participating in the CAP waiver. The State's process for developing an individual's plan of care required the plan to be based on the client's initial assessment or periodic reevaluation. The plan had to be updated annually and contain descriptions of the type of services the client would be furnished, the amount, frequency and duration of each service, and the type of provider that would provide each service. Space was also provided on the plan of care to list the individual's short range goals, service needs, how the services would be provided, who would provide the required services and the established monitoring plan.

The approved waiver assigned responsibility for preparing the actual plan of care to case managers. Case managers were required to work with the client, service providers and other involved parties to ensure all of the client's needs were addressed in the plan of care. Case managers also had the responsibility for ensuring clients had the opportunity to choose among the various services offered under the waiver that could meet their assessed needs. Once the plan of care had been prepared, it was submitted to the client, or their representative for approval. If these individuals had any suggested changes to the plan of care they could discuss them with the case manager. Once the final plan had been agreed upon, each party signed the document and the client could begin receiving waiver services.

We reviewed the case records for 80 waiver participants and found 79 records contained a plan of care. We were told the case file for the one individual did not contain a plan of care because one had never been prepared for the person. Of the 79 plans of care we located, only 12 were acceptable. The other 67 plans were outdated, incomplete or prepared without input from the client, guardian/representative or case manager. We also found one case where a plan of care was prepared for an individual whose assessment showed he was not eligible for waiver participation. The specific problems we identified during our review of the 79 plans of care are as follows.

- Eight cases where a Voluntary Participation form could not be located.
- Thirty-eight people who did not have their plan of care updated within the required 12 month time period. The time between these clients' updates ranged from 13 to 93 months.
- Two plans of care were based on assessments over 64 months old.
- Two cases where we could not determine when the client's previous plan of care was completed.
- Eighteen cases where no people were listed as participating in the development of the client's plan of care.
- Twenty-five cases where the documentation indicated the case manager did not participate in the development of the client's plan of care. This observation confirmed the apparent common practice of having service providers instead of the responsible case managers develop plans of care for CAP participants.
- Two plans of care where the client was not listed as participating in its

development.

- Thirteen cases where there was no information documenting that the client's guardian/representative participated in the development of the plan of care.
- Twenty-two plans of care were missing the signature page or lacked the client/guardian/representative signature.
- Twelve cases where a letter was used to secure the client's agreement that a new plan of care was not necessary. These letters did not include a statement concerning the client's appeal rights and some of the letters informed the client the plan of care was required only to secure federal funding for the cost of CAP services. Six of the letters agreeing to forgo a new plan of care were signed by the client's service provider rather than the client or her/his representative.
- Twenty-four instances where a standard, form letter, plan of care was used. The typical standard plan template merely stated the client's goals (live in the least restrictive setting, meet all health care needs, continue to participate in day programs, vocational placement, community integration opportunities, etc.) and provided very general service descriptions that were not specific to the individual. The standard plans also provided lists of general provider types rather than specifically identifying the providers who would be providing services to the client. Six of the standard language plans were open-dated.
- Numerous examples where the CAP plan of care referenced service plans used for Medicaid personal care services or developed by residential and vocational service providers. Unfortunately, the provider plans were rarely included in the clients' case files nor did they cover the same time period as the CAP plans of care.
- Twenty-seven cases where the plan of care did not contain information on: (1) the client's last physician or dentist visit; or, (2) monitoring activities required to ensure compliance with, and the effectiveness of, treatment regimens.
- Six cases where the client was assessed to have needs that were not addressed in the plan of care.

We did not identify a policy or procedure that would account for the problems with documenting client choice. We believe future problems in this area could be prevented by educating staff on the importance of ensuring that clients are allowed to exercise their freedom of choice and by documenting these decisions in the clients' case files. The situations where the clients' plans of care did not address all of their needs appeared to have resulted from DDD not having sufficient funds to pay for the needed services. This problem is covered in more detail in the finding titled Access to Needed Services. The cause of the other problems found during our review of plans of care appeared to be a lack of adequate staffing. We were unable to determine if the staffing shortage was the result of inadequate funding by the legislature or a decision by DSHS to allocate staff resources to other activities. We did conclude the plan of care process was seriously flawed and functioned in a manner that clearly was not in the best interest of the people being served through the waiver. It is important to note the plan of care is the tool used

to document the services a client will need to live in the community and who will be responsible for providing those services. The plan of care is also used by case managers to identify those aspects of a client's placement that require monitoring. The results of not having timely and comprehensive plans of care are obvious: DSHS had no assurance people were receiving the services they needed and case managers lacked information critical to monitoring the success of the client's placement. Stated differently, DSHS did not have reliable evidence indicating CAP participants were not exposed to unreasonably high risks to their health and wellbeing.

Our review of the process for developing plans of care also involved numerous interviews with DDD staff, client representatives and advocates. These interviews revealed CAP clients were being denied their choice among waiver services. The typical situation involved a client needing residential habilitation. By definition, the client would qualify for either adult family home, group home or supported living/tenant support; however, the person would be offered only group home services. The reason usually given for limiting the client's choice to group home services was funds were not available for the other services. As discussed in the finding titled Access to Needed Services, services cannot be denied clients because of a lack of funds. A Medicaid beneficiary's freedom to choose among services is further protected by 42 CFR 435.230 (sufficiency of amount, duration and scope of services) and 42 CFR 435.240 (comparability of services). These regulations preclude States from denying services to Medicaid beneficiaries for reasons other than medical necessity or a person's abusive utilization patterns. Denying Medicaid beneficiaries their freedom of choice is a very serious compliance issue and could result in sanctions against the State. It is also a violation of the beneficiaries' rights and results in reducing the quality of life for the affected people.

Discussions with DDD personnel further disclosed that management had adopted a policy requiring plans of care to be updated on a biannual versus annual basis. We were told this decision was necessary to reduce case manager workloads to levels that could be managed with available staff. Management also allowed plans of care to have effective dates prior to the date the plan of care was signed by the client/representative/guardian and encouraged case managers to request clients/representatives/guardians post-date their signatures. We did not determine why these policies had been adopted but they clearly conflict with the requirement for clients to approve the plan of care before its implementation. The policies also indicate a lack of concern about maintaining the integrity of the plan of care process.

Providers of Waiver Services

The design and implementation of a system for assuring that waiver services are provided by qualified providers is critical to the success of home and community-based services waivers. The State addressed this need by establishing licensing, certification and other standards for providers of each service offered through the CAP waiver as well

as monitoring systems to ensure providers continued to meet established standards. An individual or organization desiring to become a provider of CAP services was required to present documentation showing they met the minimum qualifications established for the service they were interested in providing. Depending on the service, this documentation could include a license, certification or other evidence the applicant met the established qualification standards. Potential providers were also required to provide references and undergo a background check. Individuals interested in providing individual services, such as attendant care, were given a handbook that described the various provider qualification requirements, universal health precautions, liabilities associated with caregiving, contracting procedures, need to respect individuals and several other important aspects of being a CAP provider. Once an applicant had been approved, they were required to sign a contract. Contracts followed a standard format and contained a "termination for convenience" clause. DSHS also contracted with counties to provide various habilitation services. These contracts held counties accountable for establishing an evaluation system, referring all subcontracts to the DDD regional office for approval and conducting on-site monitoring of subcontractors. DDD and county personnel jointly participated in the monitoring of subcontractors.

Our review showed DSHS did a commendable job in establishing standards for providers of CAP services. We also found the licensure, certification and other monitoring activities had proved effective in ensuring providers remained qualified and fulfilled their contractual obligations. The monitoring activities allowed DDD the opportunity to verify providers received the training required to maintain their license or certification. DDD also encouraged providers to participate in the development of plans of care for CAP participants. This provided an excellent opportunity for providers to share valuable information with other people involved in the process as well as to learn more about a client's needs and other services that may be available to the client.

Level of Care Need

The approved waiver limits participation in the CAP waiver to those individuals who require the level of care provided in an intermediate care facility for the mentally retarded (ICF/MR). The State ensured this restriction was enforced by requiring each individual entering the CAP waiver have an evaluation to determine if they required the appropriate level of care. According to the approved waiver document, the criteria used for determining the level of care of waiver participants is equivalent to the criteria used for determining the level of care for institutionalized individuals. The process began with the assigned case manager gathering information on the client's goals, health status and needs. The case manager used this information, along with input from health professionals and others familiar with the client, to prepare an initial assessment. Input was also obtained from staff of the DSHS, Division of Mental Health when the individual's condition indicated a need for coordination with this unit. Upon completion of the assessment, the results were entered into the computer for scoring and determination of

the service needs of the client. The completed assessment was then referred to a Qualified Mental Retardation Professional (QMRP) for review and sign-off. Upon completion of the QMRP review, the assessment was inserted into the client's case record. The approved assessment was then used as a basis for developing the person's plan of care. Each individual participating in the CAP waiver was also required to have an annual reevaluation to ensure they still qualified for CAP participation and their current needs were identified.

Timely and Appropriate Assessments - We reviewed the case records for 80 individuals who participated in the waiver during our review period and found each person had received an initial evaluation or reevaluation of their need for ICF/MR level of care. Only one individual was assessed as not meeting the level of care requirements of the CAP waiver. This individual was allowed to continue to participate in the waiver because the case manager did not know how to remove the client from the waiver. We found 37 of the reevaluations were not completed within the required 12 months. We could not determine the time period between one client's current and previous assessments because information necessary to make this determination was not available. The time elapsed between evaluations for the 37 clients ranged from 13 to 93 months. Twelve of the 37 individuals had to wait 48 months or longer for their reevaluations. The case where the person had to wait 93 months between assessments was especially egregious. This individual went from being assessed as relatively self-sufficient and having minimal needs to having significant needs and requiring a great deal of assistance to avoid placing her health and welfare in jeopardy. Examples of where her assessed needs changed significantly include going from: requiring no support in toileting, dressing and grooming to needing total support and assistance in these areas; needing only reminders with manners and appearance when eating to needing physical help in order to eat; being capable of completing all of her household tasks to requiring others to perform all of these tasks; requiring only minimal supervision in planning and preparing meals to having to totally rely on others for food preparation; and, needing only occasional monitoring of health needs to requiring consistent supervision of her health and instruction on how she should take care of her health needs. The lack of timely reevaluations make it likely this client did not receive necessary services during the 93 months. This could have led to an exacerbation of her condition.

Our review of DDD's needs assessment activities also revealed case managers sometimes relied on the clients' care providers to perform the required annual reevaluations. In these instances, the case manager would ask the provider to complete the assessment for a client. The provider would complete the assessment and communicate the results to the case manager. The case manager would then prepare the official assessment form, sign it and place it in the client's case file or sign the assessment form prepared by the provider and place this document in the client's case file. We were told the practice of relying on people other than the case manager to conduct annual reevaluations was limited to those situations where the client was receiving one of the CAP waiver's residential services. DDD personnel also informed us

that case managers would often elect to copy and re-date a client's assessment for the previous year rather than spend time reevaluating the client. We were unable to determine the exact extent of these two practices but interviews with DDD staff indicated they were widespread.

The problem attributable to the case manager not knowing how to remove a person from the waiver did not appear to exist elsewhere in the State. We believe DDD could ensure this problem does not recur by providing case managers with proper training and adequate supervision. Staff at each DDD office we visited stated the other problems with the timeliness and appropriateness of client reevaluations could be attributed to inadequate staffing levels. We were told case managers were assigned such high caseloads that it was virtually impossible for them to comply with the requirement for annual reevaluations. DDD staff also stated the high caseloads encouraged case managers to rely on providers to do the reevaluations and elect to reuse previous assessments. We did not determine why the State did not adequately staff the case management function. The decision clearly resulted in DSHS violating the provisions of the CAP waiver. It also resulted in DSHS compromising the integrity and validity of the assessment process and placing CAP clients at undue risks to their health and wellbeing. This is especially true given the importance that is placed on a client's assessment when developing the plan of care.

Exceptions to Policy - We also found a number of the people included in our sample did not require the level of care provided in an ICF/MR. Discussions with DDD personnel along with analyses of the case records for these people revealed DDD had adopted a policy of extending CAP participation to selected individuals who did not meet the waiver's level of care requirement. The documentation confirmed that most of these people were placed on the waiver to capture Federal Financial Participation (FFP) for the cost of services that would have otherwise been the sole responsibility of the State. Extending CAP participation to these ineligible people was accomplished through DDD's Exception to Policy (ETP) process. The ETP process was administered at the DDD regional office level with each regional office having discretion over who would be granted an ETP. To determine the extent of this problem, we requested each DDD regional office provide a listing of all ETPs granted. The listings we received showed 274 people gained CAP eligibility through ETPs. Many of the approved ETPs were requested solely for the purpose of allowing the person access to CAP services. Others were requested to gain access to regular Medicaid State plan services. The CAP waiver was used as a vehicle to gain access to regular Medicaid services because the waiver offers Medicaid eligibility to non-institutionalized individuals with higher incomes than allowed under the State's regular Medicaid program. The CAP waiver extends Medicaid eligibility to people with monthly income up to 300 percent of the Federal Benefit Rate (\$1635) while the maximum income a non-institutionalized person could have to qualify under the State's regular Medicaid program is \$557. Extending waiver eligibility to individuals with income up to 300 percent is authorized by 42 CFR 435.217. These regulations also restrict the availability of the higher income standard to people who have been

determined to need waiver services to remain in the community.

The people granted ETPs clearly failed to meet the level of care requirements for receiving Medicaid State Plan services through 42 CFR 435.217 and accessing CAP waiver services. We estimate the individuals who received ETPs were provided CAP services totaling \$ 3,574,505. The cost of Medicaid State Plan services inappropriately provided people with ETPs is estimated to be \$1,455,603. We estimate the unallowable FFP associated with the CAP and State Plan services is \$2,575,077.

Waiver Administration

DSHS has sole responsibility for administering the CAP waiver. DSHS' responsibilities include providing due process when handling requests for waiver services and observing due process in the operation of the waiver. The due process provisions of the CAP waiver require DSHS to inform Medicaid beneficiaries who qualify for the waiver, or their legal representative, of the option to participate in the waiver and the choice of feasible alternative services under the waiver. DSHS must also provide beneficiaries who have been denied the choice to participate in the waiver or their choice of waiver services an opportunity to request a fair hearing. DSHS established procedures requiring individuals participating in the CAP waiver to be orally advised of their right to a fair hearing at the time they are denied waiver participation or their choice of services. Along with their rights, the clients should be told the time period in which a request for a fair hearing must be requested and where the request should be sent.

We examined four cases where the client requested a fair hearing. The review of these cases involved gathering information through analyses of case records and fair hearing documents as well as discussions with client representatives, advocates and DDD staff. In all four cases, we found DDD had complied with applicable CAP waiver requirements and followed DSHS procedures. We also identified opportunities where DSHS could improve the processes used for notifying people of adverse decisions and conducting fair hearings.

The use of oral notification for a service denial proved problematic in one of the cases reviewed. The case involved an apparent breakdown in communication between the case manager and the client's representative. The result was the client's representative was not sure whether the discussion she had with the case manager was an informal update on the status of the case or the official denial notification. Confusion of this nature could prove very detrimental to the client given the short time period people have to request a fair hearing. We believe similar communication problems could easily be avoided if DDD adopted a policy requiring official denial notifications be communicated in writing.

Three of the cases reviewed involved fair hearings where state personnel failed to

appear for the scheduled hearing. In one case, the hearing was canceled at the last minute because the DDD representative was ill. The hearing for this case was also delayed once because the State attorney was not prepared and continued once because the State attorney needed more time to write a legal brief. These two delays added more than 30 days to the process. In the other two cases, the hearing officer issued an order of default granting the client relief. One of the default orders was appealed by the State. The appeal resulted in the default order being vacated and a new hearing scheduled. The other default order had not been appealed as of the last day of our field work; however, the client's representative indicated she was advised to expect the State to appeal the decision. We spoke with several individuals involved in these three cases and each person indicated the delays proved stressful and were costly in terms of time and resources. State staff failed to appear at hearings in 3 out of 4 cases and caused a number of other delays. This strongly suggests the fair hearing process was given a relatively low priority; otherwise, steps would have been taken to ensure staff met their obligations. DSHS could prevent these types of delays from occurring by recognizing the importance of the fair hearing process. The possibility of future delays occurring could also be reduced if personnel were educated on the critical role fair hearings have in ensuring people receive due process. Staff may also benefit from learning the adverse effects delays can have on the people involved.

Financial Accountability

The State had established comprehensive policies, procedures and systems to ensure financial accountability was maintained. The CAP waiver was also included in the State Auditor's OMB Circular A-133 audit (single audit) of DSHS and subjected to a variety of other audits and reviews. Special audits conducted by the State Auditor or DSHS internal auditors are examples of the additional studies that could target DSHS and the CAP waiver. DDD also conducted self-audits of its operations. These reviews usually focused on program issues rather than financial matters. To ascertain whether the State's financial accountability efforts were effective, we performed a limited review of paid claims and the data used to accumulate CAP utilization and expenditure information.

Claims Review - We reviewed a sample of 16 claims for services provided through the CAP waiver during June 2001. The claims included billings for all of the services offered under the waiver except environmental modifications. We were informed environmental modifications were provided to CAP participants but the costs of the services were not charged to the waiver because environmental modifications had not been assigned a service code. Without a service code, the accounting system could not charge the waiver for the costs of the service or develop a claim for federal financial participation (FFP). We were told DDD was in the process of correcting this oversight.

Our review of the supporting documentation for the 16 claims showed each provider had

a valid contract at the time the services were provided; however, 8 of the contracts had effective dates that preceded the dates the contracts were signed. The period elapsed between the effective dates and the signature dates ranged from 7 to 274 days. This indicates the State may have made payments to providers for services rendered during periods in which the provider did not have a valid contract. Allowing providers without contracts to provide CAP services violates the provisions of the CAP waiver as well as 42 CFR 431.107. It could also allow unqualified providers windows of time where they could provide and receive payment for CAP services. This could result in overpayments and subject CAP participants to unnecessary risks. Our claims analyses also found: two instances where the provider was paid an hourly rate higher than specified in the provider's contract; one claim where the provider payment was based on a monthly rate while the contract stated the provider was to be paid on an hourly basis; and one case where the provider received a payment without submitting an invoice. DSHS acknowledged it did not require the provider to submit an invoice and indicated it based its payment solely on the document authorizing delivery of the service.

The number and types of problems identified suggests DSHS' systems for provider contracting and claims processing lack internal controls and are vulnerable to fraud. We were unable to reasonably estimate the possible error rates or overpayments that may have resulted from these problems as the size of our sample did not provide a valid basis for making statistical projections. DSHS should be able to determine the extent of the problems through its ongoing audit and review efforts. DSHS should also be able to determine the exact cause of the contracting and claims processing problems, ensure corrective action is taken to resolve the problems and determine the overpayments and associated federal financial participation associated with the various problems.

During our claims review, we also noted costs associated with childcare services were charged to the CAP waiver. The costs of childcare services are not allowable as childcare is not included in the list of services offered through the waiver. We estimate childcare services totaling \$192,295 (\$99,483 FFP) were inappropriately charged to the CAP waiver. At the conclusion of our fieldwork, DDD personnel were involved in resolving this issue. Staff were in the process of making the appropriate adjustments to the accounting records and refunding the unallowable FFP to the federal government.

Data Validation - DSHS is required to submit annual reports to CMS on CAP waiver utilization and costs. The information is reported using the HCFA 372 form and provides the basis for evaluating the cost effectiveness of the waiver. DSHS used data generated from the Medicaid Management Information System (MMIS) and Social Service Payment System (SSPS) in preparing the HCFA 372 report. The MMIS maintained payment data on extended Medicaid State Plan services and SSPS had data on CAP services. The SSPS system also maintained data such as client name and case number, provider name and number, service month, unit rate, amount paid, date paid, charge code, etc. We found the State's systems produced accurate information on waiver participants and expenditures.

Our analyses of the data produced by the SSPS and MMIS showed DSHS had allowed a significant number of people to remain on the CAP waiver even though they did not receive a waiver service. These people continued to participate in the waiver because DSHS incorrectly applied the provisions of 42 CFR 435.217. Regulations contained in 42 CFR 435.217 allow States to extend waiver participation to people who: require the level of care provided in an ICF/MR facility; would be eligible for Medicaid if institutionalized; and receive waiver services. It is important to note that a person who is determined eligible for services through a home and community-based services waiver is automatically deemed eligible for Medicaid State Plan services. DSHS elected to include the 42 CFR 435.217 group in the CAP waiver but limited waiver eligibility to only those people who had incomes up to 300 percent of the Federal Benefit Rate (FBR). This means a person could qualify for the CAP waiver and gain access to State Plan services if his or her monthly income did not exceed \$1635 while a person living in a community setting and not participating in the CAP waiver could qualify for State Plan services only if his or her monthly income did not exceed \$557.

We found DSHS considered only two of the three requirements contained in 42 CFR 435.217 when determining a person's eligibility for CAP participation. The two provisions were: (1) whether the individual's income did not exceed 300 percent of the FBR; and, (2) whether the person met the ICF/MR level of care requirement. DSHS failed to ensure individuals met the third requirement of actually receiving waiver services. Neglecting to apply the third provision resulted in DSHS incorrectly granting 42 CFR 435.217 status and thus CAP participation to 5006 people. It also resulted in the same individuals being inappropriately granted eligibility for Medicaid State Plan services. We calculated the unallowable costs for State Plan services provided the 5006 individuals to be \$37,831,300. The unallowable Federal Financial Participation (FFP) associated with these costs is \$19,545,258. The following chart provides a breakdown of the number of ineligible and overpayments for each waiver year.

<u>Waiver Year</u>	<u>Ineligible Clients</u>	<u>Unallowable Costs</u>	<u>FFP</u>
7/1/97-6/30/98	1,189	\$ 6,291,708	\$ 3,259,654
7/1/98-6/30/99	1,766	7,251,961	3,799,951
7/1/99-6/30/00	2,525	10,443,205	5,429,162
7/1/00-6/30/01	2,676	13,844,427	7,056,491

In deriving the amounts contained in the chart, we considered a person not eligible if he or she did not receive a waiver service in two consecutive months or within 30 days from the date they were enrolled in the waiver. The overpayment attributable to each person who did not receive a service for two consecutive months was determined by adding the dollar value of all Medicaid State Plan services provided in the second month and each subsequent month in which the person did not receive a CAP service. The overpayment

attributable to each one of the other individuals was derived by adding the dollar value of all Medicaid State Plan services provided during the month following the month of CAP enrollment and each subsequent month in which the person did not receive a CAP service.

Information gathered during our data validation suggests people who did not require CAP services were enrolled in the waiver to obtain FFP for services that would otherwise have been funded entirely with State monies. This strategy for shifting costs to the Medicaid program appears consistent with the rationale used for granting the vast majority of the exceptions to policy discussed earlier in the report. We received no information indicating another reason for enrolling people who did not require CAP services in the waiver.

Our data validation also revealed DSHS exceeded the approved ceiling for waiver enrollment during year 3 of the CAP renewal period (7/1/99-6/30/00). We found DSHS extended waiver participation to 11,788 individuals during the year even though the approved CAP waiver limited participation to 9,977 people. Data obtained from the SSPS showed the 1,811 additional clients received \$4,705,066 in waiver services during the waiver year. The FFP claimed for these unallowable services totaled \$2,438,636. We also found 866 of the additional clients may have inappropriately gained access to Medicaid State Plan services under 42 CFR 435.217. The potential unallowable State Plan services provided these individuals totaled \$2,142,349 (\$1,110,379). The excess enrollment problem could have been avoided if DSHS had submitted a timely request to raise the ceiling on waiver enrollment. An amendment request would have been considered timely if it was submitted on or before the last day of the waiver year. In this case, the last day of the waiver year was June 30, 2000. CMS approval would have ensured the waiver and State Plan services provided the additional people qualified for FFP. We also failed to find evidence suggesting DSHS intentionally chose to fund the services provided the 1,811 individuals entirely with State monies when FFP could have been easily obtained.

ICF/MR Services

Discussions with DDD personnel, advocates and others revealed that the State inappropriately restricted access to ICF/MR services. This problem apparently surfaced shortly after the State legislature passed Substitute Senate Bill 6751. Substitute Senate Bill 6751 was passed in 1998 and contained provisions precluding DSHS from offering a person, who qualified for ICF/MR care, admission to an ICF/MR facility unless DSHS offered the person appropriate community support services. The legislation also limited the provision of community support services to those services that could be funded using monies specifically designated for this purpose in the State operating budget. Another provision of the legislation prohibited DSHS from offering ICF/MR facility care or community support services in the event the designated funds were exhausted. These

legislative mandates were codified in RCW 71A.16.010. DDD Policy 3.03 listed additional limitations on the access to ICF/MR services. Among the restrictions included in Policy 3.03 were: the person must need services costing between \$253 and \$361 per day; a vacancy must exist at an existing ICF/MR facility; and, children under age 13 cannot be considered for ICF/MR placement. Policy 3.03 also prohibited placing an adolescent (age 13-17) in an ICF/MR facility but this restriction could be circumvented if the DDD Director granted an exception to policy.

The limitations described in the previous paragraph clearly violate federal regulations covering Medicaid State Plan services such as ICF/MR care. Provisions contained in 42 CFR 440.230 specifically require States to ensure services offered under the State Plan are sufficient in amount, duration and scope to reasonably achieve their purposes. This regulation allows States to limit the availability of services but only if the limitation is based on medical necessity or utilization control procedures. Regulations at 42 CFR 440.240 further require States to provide every individual in a group, such as the categorically needy, with access to services that are equal in amount, duration and scope. The provisions of 42 CFR 440.230 and 42 CFR 440.240 were also contained in Washington's Medicaid State Plan. Washington's State Plan also specifically listed ICF/MR services as covered services and provided without limitations. This means that a Medicaid beneficiary in Washington who met the medical necessity criteria for ICF/MR services was entitled to receive the service in the amount, duration and scope required by their medical needs. The only way a beneficiary could have her or his access to medically necessary ICF/MR services restricted would be if the person had a documented history of abusive utilization.

The legislative and DDD mandates precluding children under age 13 from receiving ICF/MR services and making ICF/MR services conditional on the availability of funds, access to other services and dollar value of service needs obviously conflict with federal regulations and Washington's Medicaid State Plan. This places the State in a position where its Medicaid program could be judged out of compliance with federal law and continued federal financial participation in the program jeopardized. More importantly, it results in Medicaid beneficiaries being denied services to which they are entitled. Denying Medicaid beneficiaries access to ICF/MR services could also affect CMS' decision on future requests to renew the CAP waiver as CAP services are intended to be provided in lieu of ICF/MR care. It is difficult to make an argument that CAP services are used to replace a Medicaid State Plan service when Medicaid beneficiaries do not have access to the State Plan service. We did not find a reasonable explanation as to why DDD and the legislature chose the approach taken to limit access to ICF/MR services. We can only conclude the people involved were not familiar with applicable federal requirements, Washington's Medicaid State Plan provisions or the effect implementation of the legislation and policies could have on DDD clients, continuity of the CAP waiver and future federal funding of the State's Medicaid program.

Recommendations

We recommend that the State take the following actions:

1. Follow-up on the individual deficiencies mentioned in the report and take the steps necessary to resolve each problem.
2. Instruct case managers on the importance of clients maintaining ongoing relationships with their physicians and dentists. The instructions should explain that alternative care must not be used to replace allopathic medical care and communication paths must be established among all of a client's health care providers. The State should also establish procedures to ensure case manager performance in this area is adequately monitored and evaluated.
3. Implement procedures requiring case managers to ensure CAP participants who are considering accessing alternative health care and unproven treatments or processes are fully informed of the potential risks and benefits of each choice. Procedures should also be implemented to ensure this information is communicated to the client's representative/guardian.
4. Remove all provisions from existing laws, regulations, policies and procedures that support or encourage denying CAP clients access to needed waiver services due to funding limitations. At the same time, laws and policies should be implemented recognizing the need to fully fund the waiver services CAP participants are assessed to need.
5. Continue its efforts in improving DDD client access to effective mental health services and alcohol and substance abuse treatment.
6. Implement procedures that require plans of care for CAP clients be prepared in accordance with the approved waiver. The procedures should address each of the problems identified in the finding on plans of care and contain instructions that will ensure the problems do not occur in the future.
7. Evaluate the rationale used by DSHS to make case management staffing decisions and take the steps necessary to ensure the number of staff needed to effectively case manage the people participating in the CAP waiver are assigned to that function. The State also needs to ensure sufficient administrative support is assigned to the area of case management.
8. Implement procedures requiring timely and appropriate assessments. The procedures should address each of the problems identified in the finding on

timely and appropriate assessments and contain instructions that will ensure the problems do not occur in the future. The procedures should also describe how a case manager can remove an ineligible person from the waiver.

9. Immediately discontinue the practice of using the Exception to Policy (ETP) process as a way for granting access to the CAP waiver. The State needs to return the federal funds claimed for CAP services and Medicaid State Plan services provided people with ETPs during our review period. The State also needs to determine the amount of federal funds claimed for waiver and State Plan services provided people with ETPs subsequent to June 30, 2001 and refund those monies.
10. Take immediate steps to resolve the problems inhibiting CAP clients from receiving due process. Policies need to be implemented ensuring written notifications of denials are issued and fair hearings are not unnecessarily delayed. Policies also need to be implemented prohibiting DSHS from appealing default decisions granted because DSHS personnel failed to appear at the hearing.
11. Establish policies preventing the claims payment problems identified in the report from recurring. The State also needs to conduct an audit of its Social Service Payment System and determine: the dollar amount of payments made for waiver services provided during periods in which providers did not have valid contracts; the excess payments attributable to paying for waiver services at rates in excess of the rates specified in the providers' contracts; the overpayments attributable to paying providers for waiver services on a different basis than allowed in their contracts; and, the amounts spent for waiver services not supported by an invoice. The audit should cover the entire period of July 1, 1997 through June 30, 2002 and provide statistically valid projections of the overpayments attributable to each of the four problematic areas. The State should also determine the Federal Financial Participation involved in the overpayments and refund those monies to the Federal government.
12. Implement procedures to prevent the costs of childcare services and other services not included in the CAP waiver service definitions from being charged to the waiver. The State also needs to refund the FFP inappropriately claimed for childcare.
13. Immediately discontinue extending CAP waiver participation to individuals who gain Medicaid eligibility through the provisions of 42 CFR 435.217 but do not receive a waiver service. The State needs to refund the Federal funds inappropriately spent on Medicaid State Plan services provided these

people during our review period. The State also needs to determine the monies spent on Medicaid State Plan services provided to similar people after June 30, 2001 and refund the Federal share of the payments.

14. Refund the FFP claimed for waiver services provided those individuals who comprised the group of 1811 excess enrollees in year 3 of the waiver. The State should also refund the FFP claimed for Medicaid State Plan services provided those individuals in the group who gained Medicaid eligibility through 42 CFR 435.217.
15. Take the steps necessary to achieve compliance with the Medicaid State Plan provisions relating to ICF/MR services. In addition, all personnel involved with DDD clients should be informed that people who are eligible for ICF/MR services under the Medicaid State Plan are entitled to those services without limitations.

State Comments

The State concurred with and submitted a corrective action plan to implement some of our recommendations. It disagreed with our recommendations concerning client access to health care, case management staffing, Exceptions to Policy, claims processing and payment, the application of waiver related eligibility provisions, excess enrollees and barriers to accessing ICF/MR services. The State provided a corrective action plan to implement partially our recommendations on ensuring CAP clients are fully informed about alternative health care and unproven treatments or process, eliminating the legal, regulatory and procedural provisions that encourage denying needed services based on funding limitations, and correcting the problems associated with plans of care. The State also disagreed with many of the facts and conclusions contained in the report.

Client Health - The State suggested CMS remove the recommendation which requires case managers receive instructions: (1) on the importance of clients maintaining ongoing relationships with their physicians and dentists; (2) that alternative care should not be used to replace allopathic care; and, (3) concerning the need to establish and maintain communication paths among a client's health care providers. The recommendation also called for establishing procedures to monitor and evaluate case manager performance in these areas. The State based its position on the fact CMS found the problems addressed by the recommendation at only one provider; the State had no evidence the problems identified were systemic; CMS did not state the situation at the one provider had an adverse effect on the people involved; and, the provider claimed alternative care was not used to replace regular physician visits. The response indicated the State would take steps to ensure the problems identified at the one provider are corrected; however, it had no plans to implement our recommendation statewide. The State also included in its response several references to State requirements for: (1) ensuring the inclusion of

medical needs and medications in the plan of care; (2) holding residential care providers responsible for ensuring clients receive annual physical and dental examinations in situations where the provider provides an average of 30 hours or more of service per month; (3) monitoring residential care providers' compliance with State requirements for ensuring clients receive annual examinations; and, (4) holding the individual or family member/guardian responsible for ensuring annual physicals and periodic dental examinations in situations where the CAP participant lives with the family or in his or her own residence.

Informed Choice - The State did not provide a corrective action plan to fully implement our recommendation to establish procedures requiring case managers ensure clients who are considering accessing alternative health care and unproven treatments or procedures are fully informed of the potential risks and benefits of each choice. It stated CMS concerns over accessing these types of services were limited to one provider and indicated its corrective action plan would apply only to this provider. The State further limited its corrective action to addressing only facilitative communication rather than the full range of alternative health care and unproven treatments/procedures. Accordingly, it plans to require case managers with clients receiving services through the one provider to provide written material explaining the positives and negatives of facilitated communication to those clients, guardians or representatives who are considering accessing this communication technique. The written material case managers will share with their clients is a paper authored by Douglas Bilken who is on staff at Syracuse University and is a proponent of facilitative communication.

Needed Services - In response to our finding and recommendation on the issue of denying CAP clients needed services, the State agreed to sponsor legislation to eliminate the statutory language denying clients access to needed services due to funding limitations and explain CMS' concerns in this area to the State Legislature. The State also agreed to stop using the lack of available funding as a defense in fair hearings involving CAP clients who have been denied services they have been assessed to need. Information contained in the State's response indicated the State Legislature allocated additional funds for waiver services which should lessen the likelihood CAP clients are denied needed services.

The State disagreed with our statement that withholding funds for services needed by CAP participants to successfully reside in the community placed people in situations where they faced unreasonable risks to their health and welfare. The State objected to the conclusion people were placed at an unreasonable risk because it believed the conclusion was unsubstantiated. The State indicated the CMS report did not provide information or evidence that CMS talked with or assessed the living situation of clients who were denied needed services based on the lack of funding: therefore, CMS did not have a basis for concluding the clients who were denied needed services were at risk.

Allegations of Abuse - The State disagreed with the example cited in the report where we

found no documentation showing the provider acted upon a client's allegations of abuse. To support its position, the State provided documentation indicating the allegations were reported to DDD and Adult Protective Services. The State also noted the responsible case manager and provider staff are continuing to work intensively to reduce the problematic behaviors that caused the incidents of abuse.

Plans of Care - The response to our finding and recommendation on plans of care indicated the State has implemented or is in the process of developing a wide variety of measures to address the problems with plans of care. These include developing new procedures, staff training and establishing a special unit for monitoring compliance with applicable federal and State requirements. The State also stated in the response it believed the health and wellbeing of CAP clients was not compromised because of the various problems identified with the timeliness and appropriateness of plans of care. To support its position, the State noted the CMS review did not find specific instances where an individual's health and welfare was compromised.

Case Management Staffing - In response to our recommendation to evaluate the rationale used by DSHS to make case management staffing decisions and ensure an adequate number of case managers are assigned to the individuals participating in the CAP waiver, the State provided a summary of several initiatives designed to address the apparent shortage in the number of case managers. These included performing two studies to update the workload standards for case managers and hiring additional case managers and administrative staff. The State also suggested CMS remove the language in the recommendation requiring it to evaluate the rationale used for making case management staffing decisions. The reason provided for this suggestion was the State believed further historical analysis of this issue would be of little benefit in securing the funds necessary to ensure adequate case management staffing levels. The State also objected to CMS' statement that the case manager staffing shortages resulted in DSHS not having reliable evidence as to whether CAP participants were exposed to unreasonably high risks to their health and wellbeing. The basis for the State's position was that CMS did not identify specific instances where client health or wellbeing was compromised or provide documentation concerning how client health or wellbeing were compromised.

Assessments - The State agreed with our recommendation concerning timely and appropriate assessments and took steps to correct the deficiencies noted in this area. However, the State indicated it believed the example cited in the report where the person went 93 months without a reassessment was a documentation problem and not a service delivery issue. It noted the initial assessment for this client was actually completed by the client and did not accurately reflect her needs. The State also noted the client's residential service provider adjusted the level of support it provided to meet this client's changing needs and CMS did not document neglect of the client.

Exceptions to Policy - The State objected to our finding on the use of Exceptions to

Policy (ETP) indicating it believed a vast majority of the clients involved were eligible for ICF/MR level of care and thus eligible for waiver participation. It stated it was in the process of preparing a matrix documenting the results of its review of the questioned ETPs and that this matrix would support its position concerning the waiver eligibility of the 274 clients involved. The matrix is expected to be completed soon and will be forwarded to CMS. The State also mentioned the correct number of ETPs provided CMS was 278 rather than the 275 stated in the draft report. The State indicated it did not believe the CMS reviewers fully understood the ETP process or the types of exceptions that were made. It pointed out the ETP process is a routine component of policy reflecting the recognition that a standard level of care instrument does not always cover every aspect of a client's life that must be considered when determining whether a person requires the level of care provided in an ICF/MR facility. The process allows DDD professionals to consider other factors and supporting information not reflected in either of the two CAP assessment tools but necessary to make accurate determinations of client need for ICF/MR level of care. The State also noted its policies require ETPs include a description of the client's need for ICF/MR level of care and included language clarifying ETPs should not be used to grant exceptions to the requirement CAP participants need ICF/MR level of care. To further support its position, the State referenced the provision in the approved CAP waiver allowing DSHS to consider "other supporting information" when determining a client's need for ICF/MR level of care. CMS' policy allowing states to use different evaluation process for determining eligibility for HCBS waiver services than for institutional placement was also cited.

The issue of using ETPs to waive discretionary State policies was also discussed in the response to our finding. The State did not believe CMS had the authority to disallow FFP on the grounds the ETP process had been used or internal policies may have been waived or changed. It provided references to a court decision and a DHHS, Departmental Appeals Board decision to support its contention FFP could not be disallowed. The court decision clarified that internal operation manuals do not have the force of law and the Board decision reversed a disallowance based on a state not following its own policy.

The State also objected to our finding concerning the use of ETPs as a vehicle to gain access to Medicaid services through the CAP waiver for non-institutionalized individuals with higher incomes than allowed under the State's regular Medicaid program. In support of its objection, the State submitted the following comments.

"In addition, by federal rule, individual or family income may NOT be used to prevent eligible individuals (including children) from choosing ICF/MR Medicaid services. It is not logical to make income an issue for eligible persons who choose community Medicaid service alternatives through the waiver thereby potentially forcing them to choose a more expensive ICF/MR service in order to get their health and habilitative service needs met."

Claims Processing and Payment - The State disagreed with most of the facts and conclusion presented in the Claims Review section of our finding titled Financial Accountability. It also believed the recommendation calling for various procedural changes in the claims processing area, an audit of the Social Service Payment System, and refund of the unallowable FFP identified during the suggested audit should be deleted from our report. The State based its position on removal of the recommendation on its disagreement with the CMS statements on utilizing retroactive effective dates for provider contracts, paying providers at higher rates or different service units than specified in their contracts and paying providers who do not submit invoices.

In its response to the issue of retroactive effective dates, the State correctly noted one of the nine examples contained in the draft report was effective on the date of execution rather than a previous or retroactive date. Therefore, this contract should not be considered problematic. The State also noted the practice of using retroactive effective dates is consistent with State law and federal Medicaid laws and regulations. The provisions of 42 CFR 431.108(d)(2) allowing the use of retroactive provider agreements in situations where the provider is accredited by a national accrediting organization that has been approved by CMS was cited by the State as recognizing Medicaid provider agreements can be retroactive. The State further indicated DDD entered into valid and binding oral contracts with the providers prior to authorizing services in those cases where there was a delay in executing a written contract. The response also included a statement that in no case was a provider paid to provide a service without first entering into a contract with DDD consistent with 42 USC 1396(a)(27) and 42 CFR 431.107(b). These citations contain the Federal contracting and Medicaid provider agreement requirements. Additional information included in the response indicated: DDD completed a background check or otherwise knew the eight providers; DDD made sure the providers were qualified before services were authorized; staff spend a considerable amount of time discussing various provider and contracting topics when establishing a working relationship with a provider; requiring written contracts before services can be provided could inhibit the State's ability to respond to a client's needs; and, monies should not be disallowed because all payments were for services that were actually rendered to eligible clients.

The rationale that payments should not be disallowed because the payments were for services actually performed was also contained in the response to our concerns over paying providers at different rates or service units than stated in the provider contracts and paying a provider without requiring the provider to submit an invoice. Other arguments made by the State to support its contention there was no basis for an overpayment included: providers were paid the amount specified by contract; there was no evidence that payments were made in excess of the contracted amount; paying providers monthly rates when their contracts call for hourly rates does not mean the payments were inappropriate; and, payments can be made through the Social Services Payment System without invoices but to do so is acceptable because staff obtain documentation that services were provided.

The State agreed with our finding and recommendation concerning childcare services but suggested CMS remove the recommendation from the report because it had taken the necessary corrective action. It noted the accounting system had been changed to ensure FFP would no longer be claimed for these services and FFP previously claimed for childcare services would be returned by June or July 2002.

Waiver Eligibility - The State strongly disagreed with our finding concerning the erroneous application of the provisions of 42 CFR 435.217. It also disagreed with our recommendation to refund the Federal funds associated with the Medicaid State Plan services provided the people who incorrectly gained Medicaid eligibility as a result of the State's misapplication of the regulation. The State made a number of statements to support its position. These statements are summarized as follows.

- Washington's eligibility system uses two codes (N and J) to identify CAP participants. The N code is used for people with income below the Federal Benefit Rate (FBR) and the J code for people with incomes between the FBR and the 300 percent of the FBR. The State also indicated the J code was synonymous with 217(c). No further explanation of 217(c) was provided.
- CMS restricted its review of ineligible individuals to those people with an N code. In addition, a large number of the people with an N code received SSI benefits. The State correctly noted the effect of including people who received SSI benefits in the CMS statistics resulted in an overstatement of the number of people CMS reported as ineligible. The State indicated the number of ineligible people reported by CMS for FY 2000 was overstated by 969 because of this error. No estimate was provided indicating the number of ineligible people CMS failed to include in its computations because it did not include individuals with J codes in its review.
- The recommended disallowance has no basis in law and conflicts with CMS policy.
- There is no statutory, regulatory, or CMS policy requirement for a waiver client to receive a waiver service within a specified timeframe. In addition, the 30 and 60 day periods used by the reviewers to determine the periods of ineligibility was never communicated to states prior to this review and other CMS regional offices have resisted state efforts to apply similar standards. A ruling by the DHHS Departmental Appeals Board was referenced to support the State's position concerning the notification issue.
- CMS stated policy is to encourage states to take full advantage of the special income option (42 CFR 435.217).
- Many of the people CMS determined were ineligible actually received frequent State Plan services that they would have been eligible for if they were institutionalized.
- The Federal government saved a large amount of money by providing ineligible people Medicaid State Plan services because these services prevented these people from being institutionalized.

- Requiring states to provide waiver services to every waiver participant each month would be inconsistent with CMS stated policy and would result in increased costs to states and the Federal government.
- The generous package of Medicaid State Plan services available in Washington reduces the utilization of services offered through the CAP waiver.
- The number of ineligible people would have been reduced if credit was given to the number of individuals who received environmental modification services. This possibility exists because the State did not claim FFP for the cost of these waiver services during the review period.
- The number of ineligible people would also be reduced if case management was a waiver service instead of treated as an administrative service by the State. The State based its contention on the assumption all of the ineligible people would have received at least one case management service during the periods covered by the CMS review
- There is no timetable for an individual to receive a waiver service because 42 CFR 435.217 requires "the group receives a waiver service." For the CAP waiver the group is developmentally disabled individuals and the group is receiving waiver services at any given point in time.

Excess Enrollment - The State also strongly disagreed with our finding on excess waiver enrollment and stated the finding along with the recommendation for the repayment of the FFP claimed for services provided the excess enrollees should be rejected. It provided a number of reasons why it believed the finding was flawed including: there is no basis for questioning FFP in situations where a waiver's ceiling on participation has been exceeded; states have the authority to change the enrollment ceiling of a waiver; the requirement in State Medicaid Manual requiring states submit a waiver amendment and receive CMS approval may no longer be required; states are allowed to exceed the approved number of enrollees in Model waivers; the use of the terms "should" and "expected to" clearly demonstrate the approved waiver enrollment is absolute; no law prevents CMS from granting a retroactive approval to increase a waiver's enrollment ceiling; Federal regulations do not specifically state FFP is not available for the cost of services provided to excess enrollees; and, CMS' decision to remove the requirement that states cannot exceed the approved estimates for the cost of waiver services (as long as the costs do not exceed the costs of institutional care). The State cited a number of court decisions to support its position. It also acknowledged the State Medicaid Manual contains provisions requiring states submit amendments to their waivers if they want to increase a waiver's approved ceiling and specifically stating the earliest effective date that can be approved by CMS is the first day of the waiver period in which the amendment was submitted to CMS for approval.

Access to ICF/MR Services - The State suggested CMS delete or re-write the recommendation calling for the removal of the regulatory, procedural and other barriers responsible for inhibiting Medicaid clients' access to ICF/MR services. It made the suggestion due to concerns that the recommendation would trigger a debilitating debate

in the State and divert attention from other important issues. No information was provided contesting the accuracy of the information presented in our finding on ICF/MR services or indicating the State disagreed with the conclusions reached by the CMS reviewers.

CMS Response

Client Health - We believe the problems identified during the review clearly support our recommendation for the State to educate case managers about the importance of clients maintaining ongoing relationships with their physicians and dentist, the need to establish communication paths among all of a client's health care providers and the need to ensure alternative care is not used to replace allopathic care. Although our report only addresses the problem of clients maintaining relationships with their physicians and dentist in the discussions about one provider, similar problems were identified in 27 additional cases. The details concerning these 27 incidents were provided to the State immediately upon issuance of the draft report. The State was correct in noting the problems with maintaining communication paths and using alternative care as substitutes for allopathic care were found at only one of the four providers visited. However, it is our position that the State did not have an effective mechanism to ensure situations like the one we found would not occur elsewhere within Washington and we worded our recommendation to address this concern. We also believe the potential harmful effects these types of situations could have on a person's health necessitate the State initiate appropriate preventive measures.

We also suggest the State's reliance on providers, clients and client family members/guardians to ensure CAP participants receive their annual physicals and dental examinations is misplaced. We believe case managers have the responsibility for ensuring clients receive necessary medical and dental services and attempting to delegate this responsibility is not acceptable. We also noted the State's requirements in the area fail to identify who is responsible for people who receive residential care services but whose service needs average less than 30 hours per month.

Informed Choice - The State apparently misinterpreted our recommendation on taking measures to ensure case managers inform CAP clients of the advantages and disadvantages of alternative care and unproven techniques and procedures. We intended the recommendation to apply statewide and cover all types of alternative care and unproven techniques. We do not believe it is prudent or in the best interest of CAP clients to create an environment that encourages people to make uninformed decisions on matters that may place their health at risk. The State was correct in that CMS found a problem with informing clients of the pros and cons of alternative care and unproven techniques at only one of the four providers visited. We agree the problems could have been limited to one provider but believe the problems could also be pervasive throughout the State. Our sample was not large enough to support taking a defensible position on

either possibility; however, we believe the potential risk to individuals is too high to justify not taking any preventive steps. We also believe the corrective action steps included in our recommendation provide a reasonable approach to addressing the issues we identified and will reduce the likelihood waiver participants will experience health crises because they were not provided the information needed to make informed decisions.

Needed Services - We were pleased to learn the State would sponsor legislation to eliminate the statutory language denying clients access to needed services due to funding limitations and explain CMS' concerns in this area to the State Legislature. It was also encouraging to learn the State would stop using the lack of available funding as a defense in fair hearings involving CAP clients who have been denied needed services. These commitments are a good start towards fully implementing our recommendation to remove the barriers for ensuring CAP clients receive the services they are assessed to need. To fully implement our recommendation, the State will need to proceed with removing the regulatory, policy and procedural provisions that support or encourage denying CAP clients access to needed services due to funding limitations. Policies also need to be implemented recognizing the need to fully fund the waiver services CAP clients are assessed to need and staff need to be advised the lack of available funding is not an acceptable justification for denying people needed waiver services. These additional steps are required for the State to achieve compliance with the approved CAP waiver as well as ensure the health and wellbeing of CAP clients.

Full implementation of our recommendation is also required to ensure the health and wellbeing of CAP clients is not placed at unreasonable risk. CMS recognizes that if a person is placed in a community setting but does not receive the level of services he or she has been assessed to need for the community placement to be successful it is reasonable to conclude the client's health and welfare will be at greater risk than if the client's assessed needs had been fully met. The likelihood a person's community placement will fail is also greater if their assessed needs are not fully met. The numerous complaints the State and CMS received from people, along with the transcripts of various Fair Hearings clearly showed people were experiencing crises because the CAP services they were assessed to need were being denied due to the lack of available funding. The situations reported also clearly demonstrated these people had been subjected to unreasonable risks. Placing people in high-risk situations such as those described in the complaints and transcripts is unacceptable. Placing people in situations where their community placement is likely to fail is also unacceptable.

Allegations of Abuse - Under a separate cover, the State provided CMS with a number of documents to support its position that the provider's and DDD's files contained information describing the seven incidents of client abuse cited in the report. The response also indicated the provider and case manager have worked intensely to reduce the perpetrator's problem behaviors that caused the incidents. The records provided by the State showed the client in question stopped being abused August 2000. Based on this information, we assume the aberrant behavior issues were resolved and the abuse

of the client ceased. The documentation also showed only one of the seven abuses was contained in both the provider's and Adult Protective Services' records. The remaining six abuses were contained in only one of the two sets of records. The additional information provided by the State also confirmed the majority of the corrective action taken in this case was directed at resolving the perpetrator's behavior rather than safeguarding the abused client. We would like reassurance that all clients are safeguarded from abuse.

Plans of Care - The State's response indicates it is aggressively addressing the problems identified in the area of plans of care. The steps outlined should significantly improve staff performance and enhance customer service. We did note two areas the State may wish to study further. One involves the procedure requiring a plan of care to be completed within 90 days from the date of a client's referral. The State should be aware a plan of care must be fully completed before a person can receive a CAP service. The other issue relates to the continued use of the plan of care letter. The letter will be used instead of a complete plan of care when the client and/or the client's representative/guardian indicate a new plan of care is not needed. The letter will only be used in cases where the client or the client's guardian/representative signs and returns the letter to the appropriate DDD staff. We suggest the State examine the use of the plan of care letter and ensure it provides a mechanism for all parties who should be involved in the development of a client's plan of care to participate in the decision of whether to continue to use the existing plan of care for another year.

The State's contention that the health and wellbeing of CAP clients was not compromised because of the various problems identified with the timeliness and appropriateness of plans of care also warrants a response. Clearly, a situation where 67 of the 79 plans of care reviewed were outdated, incomplete or prepared without input from the client, guardian/representative or case manager indicated people were placed in community settings without adequate plans of care. Given the important role plans of care play in ensuring people receive the services they have been assessed to need, it is logical to conclude the absence of adequate plans of care created a situation where people were at unreasonable risk to their health and wellbeing. The State also noted the CMS review did not find specific instances where an individual's health and welfare was compromised due to untimely and inappropriate plans of care. As stated previously, the CMS review was designed to evaluate the State's policies and procedures for ensuring people were placed in situations where their health and wellbeing was not placed at unreasonable risk and not to identify adverse events. The review provided ample evidence CAP clients were placed at unreasonably high risk to their health and welfare because of the problems with plans of care.

Case Management Staffing - Although the State is involved in several initiatives designed to address the shortage in the number of case managers and related administrative staff, it did not provide a specific assurance it would allocate sufficient staff to effectively case manage those people enrolled in the CAP waiver. CMS needs this assurance given the

uncertainty as to whether the additional staff authorized by the State Legislature will be adequate to resolve the case manager shortage and the lack of a contingency plan in case the State encounters unforeseen obstacles in securing the needed staff. We also believe compliance with CMS expectations will require the State to evaluate the rationale used to make case management staffing decisions. One example indicating a possible shortcoming of the rationale traditionally used is DSHS' inability or reluctance to reassign case management staff from other departmental activities to the CAP waiver program. We view the case management staffing issue as critical to the success of the CAP waiver and the issue must be resolved if the State wants to continue to serve DDD's clients through a home and community-based services waiver program.

The State also needs to recognize that the shortage of case managers places the organization in a situation where it does not have reliable information as to whether CAP participants have been exposed to unreasonably high risks. The evidence found during the CMS review clearly showed the case managers did not have the time or information required to prepare needs assessments or plans of care for many waiver clients. Numerous examples were also noted where the case manager did not talk to the client or their representative for over a year. Given this situation, it is not reasonable for the State to conclude case managers for these people had the information necessary to ensure the individuals were not exposed to unreasonable risks. Further support for CMS' position can be found in a recent court case involving a DDD client who was abused and forced to live in a deplorable environment. The case manager for this person was found to have failed to maintain contact with the client or obtain reliable information on the client's living conditions. This example clearly shows how important information is in maintaining clients at acceptable risk levels and documents the need for the State to devote the staff resources necessary to capture and evaluate the required information. It is also not reasonable for DSHS to dismiss this problem because CMS did not identify specific instances where client health and welfare was compromised or provide documentation concerning how health or wellbeing were compromised. The issue is not whether adverse events occurred. The issue is that the State did not take the steps necessary to ensure it had the information necessary to determine if people were placed at unreasonably high risk.

Assessments - The corrective action plan submitted for addressing our recommendation concerning the timeliness and appropriateness of client assessments appears to contain the steps necessary to resolve the deficiencies noted in the report. We are concerned about the State's comments regarding the example where the person went 93 months without a reassessment. We are perplexed as to how this case can be considered merely a documentation problem when the State had the client do her own assessment and apparently delegated sole responsibility for ensuring the client received appropriate services to the client's residential care provider. Both of these functions were clearly the responsibility of the client's case manager and should not have been delegated to the client or provider. The case file for this client also showed her plan of care was not updated for over 7 years. The documentation clearly shows DDD staff were unaware of

this client's assessed needs. We also believe the State has a very serious problem if it allows clients to assess their own needs and providers to control the services a client receives. It is especially problematic when you have a client, such as the one in our example who needed services beyond those available through the provider, having delegated responsibility for the client's plan of care. Implementation of our recommendation will ensure the problem with this one client is resolved and similar problems of this nature do not occur in the future. In response to the State's statement that CMS did not document that this client was neglected, we contend that allowing a person on the CAP waiver to go over 7 years without an assessment or up-dated plan of care can be viewed as a very serious form of neglect.

Exceptions to Policy - The State correctly noted the number of ETPs questioned in the report was incorrectly stated. The correct number was 274 and the necessary corrections have been made to the report. We are not clear why the State concluded there were 278 as the worksheets we provided the State showed there were only 274. However, we will address the additional 4 ETPs when we receive the complete results of the State's follow-up review. If we find the additional 4 cases unallowable, we will add them to our list and take appropriate action to recover the additional overpayments.

The response to the finding and recommendation on ETPs included several other statements that warrant a response. We are not clear why the State concluded the CMS reviewers did not fully understand the ETP process or the types of exceptions that could be granted through the process. On several occasions DDD personnel explained both the ETP process and types of ETPs granted to the review team. CMS staff were also aware the approved CAP waiver allows the State to grant waiver eligibility to people who do not qualify using the approved assessment instruments if a QMRP determines through other supporting information (e.g., the client's individual service plan, psychological evaluations, social work evaluations, nursing evaluations, speech and hearing screenings, and/or other professional evaluations as necessary) the client requires ICF/MR care. The approved waiver also states the QMRP must document this determination on a prescribed form that is filed with the case manager. This process was submitted by the State and approved by CMS; therefore, the State is obligated to follow the process in all instances where waiver participation is granted to a person who does not meet the ICF/MR level of care requirement using one of the two standard assessment tools. The documentation provided by the State during our review did not include information indicating the process described in the approved waiver document was followed. The documentation did show the 274 ETPs reviewed were granted to people who did not need ICF/MR level of care or needed to take advantage of the higher income limits available through the CAP waiver in order to gain access to Medicaid State Plan services. In addition, the information provided to CMS subsequent to the issuance of the draft report contained only statements that people required ICF/MR level of care. No documentation supporting these statements was provided. The additional information also stated a majority of the 274 people had scored a high enough score on their assessments to qualify for ICF/MR level of care. This supports the contention that

ETPs were used to capture FFP for services that would otherwise be the sole responsibility of the state rather than the intended purpose as described in the approved waiver. Unless the State provides us with compelling evidence contradicting our findings our position on this matter will remain as stated in the finding and we will seek recovery of the inappropriately claimed Federal funds.

We were not sure why the State included a discussion of CMS' policy for allowing states to use different assessment processes for determining eligibility for HCBS waiver services than for ICF/MR admission in its response to our finding. Our finding addresses the State's failure to comply with Federal requirements and the approved waiver document. It is not related to using different assessment processes for determining eligibility for waiver and ICF/MR services. We also question the relevance of the State's arguments supporting the use of ETPs to waive discretionary State policies in its response. The finding deals only with the use of ETPs to circumvent requirements contained in the approved waiver and Federal law and regulations. In addition, we did not question any Federal funds based on the State's non-compliance with its own policies. We also question why the State included a statement that federal rules prohibit using an individual's or family's income to prevent eligible people from choosing ICF/MR services as the 274 people were not eligible people and the ETP issue had nothing to do with people choosing ICF/MR services. As previously stated, the 274 individuals in question were not eligible. These people clearly failed to meet the legal requirements for becoming eligible for either CAP or Medicaid State Plan services.

Claims Processing and Payment - The State's response to our findings on contracting procedures and claims processing provided further evidence that a comprehensive audit of these areas is needed. We do not object to the State having retroactive effective dates for contracts if during the retroactive periods the providers are fully qualified to provide the contracted services and required to fully comply with the provisions of 42 CFR 431.107(b) and other applicable State and Federal contracting requirements. The discussion about compliance with 42 CFR 431.108(d)(2) is not relevant because this regulation does not apply to any of the providers/contracts covered in our finding. The statements made by the State with regard to this issue also raise additional concerns. We originally believed the issue with the contracts was retroactive effective dates (effective dates prior to the signature dates) but the State's response indicates the providers had valid and binding oral contracts during the retroactive period. This raises the question, why would the State make a contract retroactive if it already had a valid contract during the retroactive period? The State needs to respond to this question and provide further documentation supporting the legality of using oral contracts in these situations. The statement that in no case was a provider paid to provide a service without first entering into a contract with DDD consistent with 42 USC 1396(a)(27) and 42 CFR 431.107(b) also raises concerns as a provider must agree to comply with requirements of 42 CFR 431.107(b) before a service can be delivered. The State should recognize it is not acceptable to allow providers to wait until a claim is paid to achieve compliance with 42 CFR 431.107(b). We found the other statements provided by the

State on the use of retroactive contracts informative but they did not alleviate our concerns over the State's contracting process

The response to our findings on paying providers at different rates or service units than stated in their contracts and paying a provider without requiring the provider to submit an invoice also tends to verify our conclusions and validate the need for an audit of this area. The State's comments that providers were paid the amounts specified by contract and there was no evidence that payments were made in excess of the contracted amount have little credibility given the two examples where we found the providers were clearly paid at rates higher than those specified in the contracts. The statement made by the State that paying providers monthly rates when their contracts call for hourly rates does not mean the payments were inappropriate has little value or relevance to our finding as the payments would be appropriate only if the hourly rate times the number of hours equaled the monthly rate. This argument also assumes the contract includes a monthly rate, which was not the case in the situation reported in our finding. The State did not provide documentation showing the amount paid in the case identified during our review was derived by multiplying the hours of service times the contract rate. Lastly, we are very concerned the State would imply that it is acceptable for its Social Services Payment System (SSPS) to process claims and pay for services not supported by invoices. The statement that field staff always maintain documentation to support claims for which there are no invoices also supports our concerns in this area as the State was unable to provide CMS with the documentation necessary to support a claim for FFP in the case we identified. Although the State presented arguments for allowing FFP in the four situations CMS found problematic, it did not address the larger issue of having a claims processing system that would make a payment based on information that conflicted with the provider's contract and allow payments to be made without obtaining the information necessary to support a claim for FFP. This demonstrates a total lack of internal controls. Therefore, we continue to believe the claims processing system may be seriously flawed and an audit of the system should be conducted to determine the exact extent, cause and effect of any systemic problems that may exist. We would also expect the State to repay the FFP associated with any overpayment identified during the audit.

We were pleased to learn the State had taken steps to fully implement our recommendation concerning childcare services. However, we do not concur with the State's contention that the recommendation should be removed from the report. The State has not completed its efforts to identify the FFP that was claimed for the cost of these services or returned these monies to the Federal government.

Waiver Eligibility - The State prepared a lengthy response to our finding and recommendation concerning the misapplication of the provisions of 42 CFR 435.217. Included in the response was information showing CMS made an error in determining the number of ineligible people and corresponding overpayment. The State correctly noted that CMS mistakenly included people who received SSI benefits in its statistics and

overpayment calculations. The State was also correct in stating CMS failed to consider those individuals who had a J code when conducting its review. We have corrected these oversights and adjusted the numbers of ineligible people and overpayments on page 21 of the report accordingly.

Throughout the response, the State confused the issue of requiring a person to receive a service to become eligible for Medicaid under the provisions of 42 CFR 435.217 with whether there are federal requirements for people who have become eligible for Medicaid under other provisions of Medicaid law to receive a waiver service before Medicaid eligibility can be granted. It is very clear in the Medicaid statutes and regulations that the requirement for a person to receive a waiver service to become eligible for Medicaid is only applicable to people attempting to gain Medicaid eligibility through 42 CFR 435.217. Therefore, there is no requirement for people who gain eligibility through other Medicaid provisions to receive a waiver service within a specific time frame. It is important to stress that the finding is about the State's failure to correctly apply the provisions of 42 CFR 435.217 and the resulting effect of providing Medicaid services to a large number of ineligible people. The finding has nothing to do with any other aspects of Medicaid. Stated differently, the issue is about the State's application of Medicaid requirements that apply when determining a person's eligibility for Medicaid, not the application of Medicaid requirements that apply after a person has been determined eligible. We would also like to point out that documentation exists suggesting the State has been aware of the requirements of 42 CFR 435.217 for over 10 years. This documentation is located in Washington's Medicaid State Plan on page 11 of Attachment 2.2-A and on page 36 of the approved CAP waiver. It is reasonable to assume the State personnel who worked on obtaining the necessary legislative support and preparing the required Medicaid State Plan and CAP waiver revisions were fully aware of the Medicaid eligibility provisions contained in 42 CFR 435.217. After all, the State's decisions to add the people covered by this regulation to the groups covered by Washington's Medicaid State Plan and CAP waiver represented major program expansions.

The State also mentioned in its response that there was no statutory, regulatory, or CMS policy requirement for a waiver client to receive a waiver service within a specified timeframe. This statement is correct but fails to note a waiver client is someone who is eligible to participate in the waiver. It also fails to recognize there is a requirement for people who gain eligibility through 435.217 to receive a waiver service. The issue is whether individuals who need to receive a waiver service to become eligible for Medicaid services actually received a service, not whether people who were eligible for Medicaid under another regulatory or statutory provision received a service. It is also important to note that the people CMS found ineligible for waiver participation did not meet Medicaid eligibility requirements and could not be considered "waiver clients."

We also disagree with the State's contention that states were never notified about the 30 day requirement for receiving a service. This requirement is contained in 42 CFR 435.217. The regulation clearly states a person who is attempting to qualify for Medicaid

under its provisions must receive a waiver service. Since eligibility for people covered under 42 CFR 435.217 is determined/re-determined each month, a person must receive a waiver service each month to meet the applicable regulatory requirements. As for the 60-day period used by the review team, we gave the State an extra 30-day grace period when we were determining ineligibility and the overpayment amounts.

The State also implied our finding conflicted with CMS policy encouraging states to take full advantage of the provisions of 42 CFR 435.217 and extend waiver participation to every person who qualifies. Unfortunately, Washington extended waiver eligibility to people who did not qualify under 42 CFR 435.217.

Several arguments regarding CMS enforcement of compliance with 42 CFR 435.217 were also contained in the State's response. The arguments included: (1) some people who did not receive a waiver service actually needed medical care; (2) children often have their medical needs met through the EPSDT program instead of a home and community-based waiver program; (3) serving the people who were ineligible for Medicaid actually saved the Federal government money; (4) the regulation penalizes people who have family supports; (5) the regulation conflicts with CMS policy to allow waivers in situations where the participants infrequently use waiver services; (6) utilization of waiver services is reduced by the requirement for free choice; (7) some waiver services are designed to be used episodically; and, (8) Washington is being penalized because it has a generous Medicaid program. Although these arguments may have merit when used in a different context, they do not provide a reasonable rationale for the State to violate the law or for CMS to forego fulfilling its obligation to enforce Medicaid law.

The State's response to our finding and recommendation also contained two additional statements we believe warrant a detailed response. The first statement was, "The State should not be penalized for how it has exercised its discretion about how to allocate needed services between the waiver, Medicaid administration, and the State plan." The State believed it was being penalized for not billing the federal government for environmental modifications and its decision to cover case management as an administrative cost rather than a Medicaid State Plan service. The State failed to provide CMS with one instance where a person we determined was ineligible actually received an environmental modification or any other waiver service nor did it provide any other factual support for its statement.

As for covering case management as an administrative service, the State made this decision because it believed case management was necessary for the efficient and economic operation of its Medicaid State plan and the service should be available to all of its Medicaid clients. There are also several other factors that make offering this service as an administrative service versus a Medicaid State Plan service advantageous to the State. The statement that every CAP participant would have received a waiver service during the time periods under review is also highly questionable. We find it

extremely unlikely every client who was ineligible would have received a case management service given the various problems we found during the review and the State's admissions concerning the shortage of case managers. In summary, CMS is not penalizing the State for these decisions, it is holding the State accountable for them.

The second comment we believe requires a specific response is that every person enrolled in the waiver requires waiver services and all eventually use CAP services. Our review identified a number of people who were enrolled in the waiver but whose assessment indicated they did not need a waiver service. In addition, the State did not provide CMS with any evidence showing all enrollees actually need or were provided waiver services. We also question the assumption that all CAP clients will eventually use waiver services as we found many people who were enrolled in the waiver for the entire four year review period but received no waiver services. The likelihood the State has access to a method to project with 100 percent certainty that all people who were enrolled during the four-year review period will eventually receive a waiver service is remote.

Excess Enrollment - The State did not provide a convincing argument for removing our finding and recommendation on excess waiver enrollment from the report. The information contained in the State's response did not provide a reasonable justification for CMS to treat the issue of waiver enrollment in a manner that conflicts with the requirements set forth in the State Medicaid Manual. It is important to note that the approval letter for the CAP waiver clearly states the approved ceiling for the waiver for the year in question was 9,977 unduplicated individuals. The State also failed to provide adequate justification for CMS to allow FFP for the cost of services provided to people who have received services but have been determined to be ineligible by CMS.

Access to ICF/MR Services - Based on the State's response to our suggestion for removing the various barriers to ICF/MR services, we made minor revisions to our recommendation. We remain committed to ensuring Medicaid clients are not inappropriately denied access to State Plan services and look forward to working with the State on resolving the access issues identified in the report.